ND Medicaid Provider Name: ____________________________ **ND Medicaid Provider #:** ___________

DOCUMENTATION FORM

Medicaid Member Last Name: ____________________ **Medicaid Member First Name:** ________________

Medicaid Member ID#: __________________________

Date of Service (Transport): ___________________________
(Month) (Day) (Year)

Pick Up Address: ____
(Address) (City) (State)

Drop Off Address: ____
(Address) (City) (State)

Odometer Reading At Pick Up: ____________ **Odometer Reading At Drop Off:** ____________

Number of Loaded Miles: _________

Medicaid Member Last Name: ____________________ **Medicaid Member First Name:** ________________

Medicaid Member ID#: __________________________

Date of Service (Transport): ___________________________
(Month) (Day) (Year)

Pick Up Address: ____
(Address) (City) (State)

Drop Off Address: ____
(Address) (City) (State)

Odometer Reading At Pick Up: ____________ **Odometer Reading At Drop Off:** ____________

Number of Loaded Miles: _________

Medicaid Member Last Name: ____________________ **Medicaid Member First Name:** ________________

Medicaid Member ID#: __________________________

Date of Service (Transport): ___________________________
(Month) (Day) (Year)

Pick Up Address: ____
(Address) (City) (State)

Drop Off Address: ____
(Address) (City) (State)

Odometer Reading At Pick Up: ____________ **Odometer Reading At Drop Off:** ____________

Number of Loaded Miles: _________
